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CHILDHOOD ABUSE, RESILIENCY, AND PSYCHIATRIC OUTCOMES
IN A COLLEGE SAMPLE OF WOMEN: A MODEL

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Psychology:
General-Experimental


by
Laura Liliana Luna
June 2007

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ABSTRACT

A vast amount of child abuse research has established the abuse experience to be detrimental to psychological well-being, often leading to the development of psychiatric outcomes. However, not all individuals who experience abuse become dysfunctional. Individuals able to overcome the adverse effects of abuse leading functional lives are described as resilient. In the proposed study it is hypothesized that resiliency will moderate the relationship between child abuse and psychiatric outcomes. Secondly, it is expected that shame will mediate the above mentioned relationship. Mediation and moderation effects will be tested via SPSS REGRESSION. Data was collected at CSUSB from a total of 160 women. The following measures were used to examine the hypotheses: Childhood Trauma Questionnaire, Brief Symptom Inventory, Experience of Shame Scale, Self-Esteem Inventory, the Life Orientation Test-Revised, and the Social Support Inventory. Results partially supported the hypothesis. Shame did mediate the relationship between negative outcomes and child abuse; however, a moderation was not detected. Clinicians may focus on mitigating shame symptoms and increasing social support systems.

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CHAPTER ONE

INTRODUCTION

Background

In the recent past, children have been considered smaller and less capable versions of an adult. Only in the last one hundred years have children been perceived as vulnerable and in need of protection. In some countries, there is still a need for legislation to protect children, and it was not until the late 20th century that legislation was developed here in the United States to protect the rights of children (Miller-Perrin & Perrin, 1999).

When child abuse research began in the 1960's, clinicians did not take the negative effects of child abuse seriously. Qualitative research found that a considerable amount of incest occurred, however, again, clinicians were unwilling to break the silence due to the belief that incestuous abuse was rare. Russell's (1986) extensive investigation found that certain psychologists did whatever they could to minimize the importance of incest.

For example, Kinsey (cited by Russell, 1986, p. 6-7) interviewed many individuals who reported childhood sexual

abuse experiences. He reported that he could not understand why a child would be upset about being fondled or touched by an adult, concluding that because child sexual abuse did not result in physical harm there was no reason to deem it important or traumatic. Additionally, Freud's Oedipus Complex Theory contributed to the notion that children are to blame for abusive experiences, and in turn increasing their feelings of shame and self-blame.

Research has advanced since the 1960's and since Kinsey's and Freud's research; however, investigators have a significant amount of work to accomplish before the problem of childhood abuse is resolved, especially because childhood abuse continues to be a tremendous societal problem. For example, in 2002, an estimated 1,400 children died from abuse or neglect at a rate of 1.98 deaths per 100,000 children (U.S. Department of Health and Human Services, 2002). Individuals primarily responsible for the abuse were the parents or caretakers of the children. Research indicates that abusive experiences are apt to lead to serious maladaptations in psychological well-being and adjustment during childhood, and can also lead to difficulties in adulthood.

Individuals experiencing abuse at any age are at risk for experiencing psychological trauma, such as anxiety,

depression, somatic complaints, post-traumatic stress disorder, and shame. They are also at risk for developing suicidal behavior, sexually risky behaviors, promiscuity, and revictimization, among the myriad of outcomes.

In an attempt to explain both the negative impact of child abuse as well as possible resiliency factors that may serve as buffers, this study tests a hypothesized resiliency model. The following is a description of the model.

Statement of the Problem

Model

The negative impact of abuse has been established in child abuse research; however, there is still much work to be done in developing useful interventions and prevention programs that will assist families who are at high risk. In the model, it is hypothesized that the presence of resiliency factors can protect individuals, particularly women, from developing psychiatric outcomes.

Although it is known that certain individuals are resilient, researchers are unsure as to what makes these individuals different and able to overcome traumatic events. The following three variables in this study are encompass resiliency: optimism, self-esteem, and social

support. Although each of these, may be considered an outcome variable of abuse, only low self-esteem has been reported to be a consequence of child emotional abuse. Moreover, the absence of a social support system (i.e., having someone to talk to) and having a pessimistic explanatory style could make the abusive experience more problematic and lead to higher degrees of negative outcomes (Cohen & Willis, 1985).

On the other hand, the presence of the three variables, proposed to define the construct of resiliency in this study, could buffer the negative impact of abuse, in turn, leading to lower levels of negative outcomes. In other words, it is hypothesized that resiliency will moderate the relationship between childhood abuse and psychiatric outcomes.

The negative psychiatric outcomes proposed in this study are identified as anxiety, depression, and somatic symptoms. These three measured variables are consequences of the experience of childhood abuse, and there is substantial research supporting this notion. Due to the prevalence of the three outcomes among populations who have experienced abuse, particularly women, these variables were identified to make up the construct of psychiatric outcomes.

The second piece in the model predicts that shame will mediate the relationship between childhood abuse and the negative outcomes. Again, it is known that child abuse leads to psychiatric outcomes; however, this relationship can be examined more deeply by investigating the effect of experiencing shame after an abusive experience (Refer to Appendix J for a diagram of the model).

Sample

It was decided to conduct this study only on women due to the high prevalence rates of the proposed outcomes. Research indicates that women who have abuse histories are at increased risk of experiencing somatic symptoms and depression. Additionally, although both females and males have reported child abuse, historically girls are at much higher risk than boys. Also, due to the deep stigmatization that typically occurs in women who are abused, it is critical that this study be conducted on women.

Limitations

The current study uses data from college students. This will limit external validity of the study. Although histories of childhood abuse certainly exist in this population, college samples are still thought to be unique

in comparison with the general population. Particularly, college samples are not likely to contain the most disadvantaged populations. Also, college students may also report higher than average levels of stress (Robotham & Julian, 2006) thereby reporting inflated levels of anxiety in this study. Furthermore, college students are also considered to be more resilient than the general population and may not display typical symptomology (Himelein, 1995).

Secondly, the measures used to collect data were self-report. It may be that abused women do not remember some of their childhood experiences, or, due to the traumatic nature of the study they may not be able to be honest regarding their experiences. However, studies on self-report suggest that this method is consistently reliable (Maughan & Rutter, 1997; Paivio, 2001). Particularly for the Childhood Trauma Questionnaire (CTQ), studies have repeatedly shown that the CTQ is stable across time even after therapy (Paivio, 2001).

With regard to the Experience of Shame Scale, although shame feelings in the last year are surveyed rather than shame feelings after the abuse experience, it is thought that shame will still be present in women who have been abused during childhood due to the deep

internalization and stigmatization which occurs as a consequence of the abusive experience.

Lastly, the analyses will be conducted using a series of Multiple Regressions. When this many regressions are performed there is always a risk for Type I error. However, this issue will be addressed by using a restricted significance value of $p < .01$.

Review of the Literature

Explanatory Models of Abuse

Traumagenic Dynamics Model. The Traumagenics Model is one of the most well known and widely cited models across child abuse research. The following four factors are identified in the model: traumatic sexualization, betrayal, powerlessness, and stigmatization. Finkelhor and Browne (1985) developed the model primarily in hope of enabling clinicians to assist sexually abused children.

However, it is important to note that the four factors proposed in the Traumagenics model are not unique to the child sexual abuse (CSA) experience. In other words, any child who has experienced any traumatic event (e.g., death of a parent) can experience one or more of the trauma causing factors. The uniqueness of the model in

CSA, is that all four factors are present in children reporting CSA.

The four factors will be discussed here; however, for the purpose of this study only the stigmatization dynamic will be examined. The first dynamic, traumatic sexualization, leads a child to engage in sexualized behaviors, occurring because often the child is rewarded for sexually inappropriate behaviors. Secondly, the betrayal dynamic can occur if the perpetrator is someone the child trusted or was vitally dependent on. Additionally, betrayal may occur during disclosure if the child is ignored or blamed for the abuse. The powerlessness dynamic refers to the process in which the child's will and desires are contravened, thereby disempowering them. Finally, the stigmatization dynamic is defined as the factor in which negative connotations of shame and guilt are incorporated into the child's self image (Finkelhor & Browne, 1985).

Finkelhor and Browne suggest that this model enables clinicians to ask specific questions with regard to each dynamic in order to develop a suitable and specific intervention for child survivors of sexual abuse. In the proposed study, the stigmatization dynamic will be explored through the examination of the experience of

shame using the Experience of Shame Scale (ESS). As noted earlier, the ESS asks questions regarding shame experiences in the last year, and not after the child abuse experience.

However, as also noted the experience of shame can be present in survivors of abuse years after the abuse experience, and therefore, it is still hypothesized that shame will be present in this sample of women. As Finkelhor and Browne suggest in their model, identifying the experience of shame is an important factor in developing interventions and prevention programs. Alleviating shame symptoms can in turn mitigate the development of psychiatric outcomes.

Ecological Systems Model. The National Research Council has identified the ecological model as a framework that may be used to address the causes, consequences, and treatment formulations for abused children. The model asserts that understanding the environment of the child is essential in determining and identifying the best treatment for the child. The ecological model takes into account the complex interactions among individual, family, community, and societal risk factors in the occurrence of child maltreatment.

Each of the factors included in the model, helps determine the increase or decrease in the risk of child maltreatment (Little & Kantor, 2002). Research demonstrates that child maltreatment is more likely to occur in families experiencing violence, maternal distress (depression), poverty, family stress, social isolation, and parental history of abuse, among others (Little & Kantor, 2002).

Osofsky (2003) further suggests that the problem is not just that children are exposed to violence, but that they learn violence may be an acceptable way for individuals to act toward one another (Walker, 1980). Osofsky also suggests that utilizing resources and support from different groups in society that impact children and families such as schools, police and community groups is likely to have a positive long-term impact on children exposed to violence.

Osofsky's work shows that it is necessary to get more people involved in resolving the issue of child maltreatment and family violence in general. The general public consumes much of their information from television and media in which violence is predominant; therefore, children are learning that violence is acceptable, particularly if parents are not teaching them otherwise.

Media violence research has found that young children watch a total of 4,000 hours of television before entering kindergarten. Moreover, 60% of cartoons and children shows contain violence. Retrieved May 31, 2007, from <http://www.ActAgainstViolence.org>

This research suggests that it is vital for parents to guide their children; however, if these parents are also experiencing intimate partner violence, the notion that violence is acceptable is confirmed in the mind of a child. Given that parents in abusive relationships may be unable to detect violence in their children; in accordance with the ecological model, it is essential to get the community involved and training them with violence awareness.

There are programs available however, that assist women who have experienced intimate partner violence. African-American, and White women will use these resources when available; however, Hispanic women experiencing intimate partner violence are not more likely to use them than their non-abused counterparts, therefore, it is particularly important to reach out to these women in particular (Lipsky, Caetano, Field, & Larkin, 2006).

Based on the ecological perspective, a good place to begin treatment could be at the individual level. Focusing

on treatment in which the characteristics of both children and parents are taken into consideration. For example, intervention programs could be developed that help parents deal with psychological outcomes (e.g. depression) while helping children develop protective factors such as coping abilities. Specifically, in the present study, the focus is on identifying protective factors in order to build on the individuals' ability to overcome the abuse experience and mitigate the risk of developing negative outcomes.

Abuse Variables

Childhood Maltreatment. As noted earlier, children have been deemed vulnerable and in need of protective rights in the United States only since the 1970's. Historical data indicate that labor laws were developed in certain states as early as the 1800's and by 1899, 28 states had some type of protection for children. Presently, there are substantial legislative labor laws prohibiting and limiting children from working in certain settings and hours; however many children continue to work illegally, especially in agricultural settings (Goldstein, 1976). While children's rights have been increasingly emphasized, many children continue to be subject to various forms of maltreatment such as sexual, physical,

emotional abuse and/or physical or emotional neglect (Callahan, Price, & Hilsenroth, 2003; Sneddon, 2003).

Research has found that the younger the child, the more at risk for being maltreated, particularly for experiencing neglect (Connell-Carrick, 2003; Hildyard & Wolfe, 2002). A vast amount of research has been published on the various types of child abuse due to the immediate and long-term difficulties associated with the experience (Miller-Perrin & Perrin, 1999; Russell, 1986; Wolfe, 1999). However, the majority of the literature involves childhood sexual abuse, whereas physical and emotional abuse are given less attention.

Part of the difficulty lies in methodological issues, such as identifying that abuse is occurring (Miller-Perrin & Perrin, 1999). In particular, it is difficult to assess if sexual or emotional abuse has been perpetrated against a child. In 2003, approximately 3.4 million referrals were made to Child Protective Services (CPS) agencies throughout the United States for suspicion of child abuse and neglect; however, many of these cases were not investigated; of the two-thirds that were investigated about 906,000 children were determined to be victims of child abuse or neglect (U.S. Department of Health and Human Services, 2005).

In cases of child sexual abuse, it is difficult to determine if a child is being abused by a parent or caregiver. Perpetrators will inevitably deny the abuse and the child may be reluctant to speak against the perpetrator, particularly if the child is being abused by a parent (Thompson & Wyatt, cited by Sneddon, 2003). However, the research on childhood sexual abuse clearly indicates severe detrimental effects to the physical and emotional adjustment of the abused individual (Browne & Finkelhor, 1986; Feinauer, Middleton, & Hilton, 2003).

The limited research conducted on child emotional abuse, is due to the difficulty in both identifying if the psychological abuse has occurred, and also because historically, it has been problematic to come up with an operational definition of emotional abuse (Sneddon, 2003). Nevertheless, it is known that emotional abuse can be the most damaging to psychological well-being (Miller-Perrin & Perrin, 1999). Therefore, it continues to be necessary to conduct investigations on all forms of childhood abuse. The three variables discussed next encompass the child abuse factor and include child emotional abuse, child physical abuse and child sexual abuse.

Childhood Emotional Abuse. Childhood emotional abuse is the type of maltreatment that is least examined and

yet, research findings suggest that it may be the most harmful to psychological well-being (Miller-Perrin & Perrin, 1999). The lack of emphasis on child emotional abuse is thought to be due to the fact that typically, there are no visibly apparent signs of emotional abuse, making the abuse elusive. The prevailing belief with regard to emotional abuse used to be that it caused no harm; however, a poll conducted between 1987 and 1997 by the National Center for Prosecution of Child Abuse, showed that 75% of people surveyed believed that "repeated yelling and swearing" at children is harmful to their well-being (Miller-Perrin & Perrin, 1999). This belief has subsequently been empirically supported (Schneider, Ross, Graham, & Zielinsky, 2005; Wolfe, 1999).

Researchers continue to struggle in operationally defining emotional abuse. One useful definition is that emotional abuse is the emotional ill-treatment or rejection of a child (Iwaniec, 2003; Sneddon, 2003). Others suggest that the definition should be limited to "parent child communications that may potentially damage the child psychologically" (McGee & Wolfe, cited by Schneider et al., p. 517). Yet most can agree that emotional maltreatment includes repeatedly belittling, denigrating or terrorizing a child, isolating him/her from

others, and/or explicitly rejecting the child (Sneddon, 2003).

According to Bernstein and Fink (1994) emotional abuse refers to "verbal assaults on a child's sense of worth or well-being, or any humiliating, demeaning, or threatening behavior directed toward a child by an older person." This definition was used in developing the Childhood Trauma Questionnaire (CTQ) and will be used for the proposed study. The CTQ has been found to have good internal consistency and reliability across a myriad of studies using both the 70-item version as well as the 28-item version in clinical and non-clinical samples in identifying all types of abuse (Paivio & Cramer, 2004). Therefore, if emotional abuse is present in this sample it is likely to be an accurate measurement of the experience.

Due to these definitional problems and due to the co-occurrence of emotional abuse with other types of abuse, researchers have also had difficulty in identifying risk factors for emotional abuse (Iwaniec, Larkin, & Higgins, 2006; Wolfe, 1999). While one study found that emotional abuse is associated with the development of depressive symptoms (cited by Gibb, Butler, & Beck, 2003), other investigators have not found clear cut associations

discussed by Iwaniec et al. (2006) in a review of the research on emotional abuse.

It has been determined however, that emotional abuse is typically the most damaging in comparison to child sexual abuse and child physical abuse (cited by Iwaniec, 1997; Sneddon, 2003). In the proposed model, the variables of interest were analyzed using Multiple Hierarchical Regressions, allowing for a useful understanding of the variable complexity which is especially necessary when examining childhood emotional abuse.

Childhood Physical Abuse. Child fatalities due to physical abuse represent 28.3 percent of all reported fatalities. In particular, children under three years of age are the most vulnerable and at risk of death representing 81 percent of all fatalities caused by some form of abuse and/or neglect (U.S. Department of Health and Human Services, 2006). In general, physical abuse refers to injuries and behaviors toward children that are other than sexual (Lutzker, Hasselt, Bigelow, Greene, & Kessler, 1998). Children may suffer broken bones, bruises, burns, damage to internal organs and even death at the hands of caregivers (Sneddon, 2003).

Bernet and Stein (1999) found that depressed patients who had been physically abused as children reported higher

levels of depressive symptoms than their non-abused counterparts. In addition, physically abused children have been found to be more aggressive than other children, and more prone to oppositional behavior, delinquency and criminality. Many of the problems associated with child physical abuse are long lasting, and extend into adulthood (Prino & Peyrot, 1994). For example, an investigation conducted on a community sample (N = 347) found that 83 women exhibited major depressive disorder and had attempted suicide, while 193 of these women experienced suicidal ideation; and suicidal ideation was strongly associated with child physical abuse (McHolm, MacMillan, & Jamieson, 2003).

Some studies have found that physically abused children become the next generation of abusive parents, however, this finding has not been empirically supported (Knutson, 1995). Yet other studies have found a relationship between physical abuse and the development of anxiety (cited by Gibb et al., 2003, p. 2). Studies seeking to find a specific relationship between one type of abuse and a specific outcome have failed, partly because of the comorbidity among abuse variables. It is evident however, that child physical abuse causes serious physical harm, psychological maladjustment in childhood

and adulthood; and individuals are at risk for being revictimized in adulthood. Therefore, it is important to continue examining child physical abuse but to go beyond merely examining impact and develop applicable interventions.

Definition of Childhood Sexual Abuse. The Diagnostic & Statistical Manual of Mental Disorders (DSM-IV-TR, 2000) does not set criteria for defining child sexual abuse, leaving it to investigators to determine what constitutes child sexual abuse (CSA). Mannon and Leitschuh (2002) conducted a review of the definitions of CSA and found a lack of consistency in defining both CSA and sexual assault leading to confusion and problems among child abuse research.

The definition varies with both the age of the child and the age of the perpetrator as well as specifics on severity of the abuse. However, consensus lies in the fact that a child is considered to have experienced sexual abuse if they were touched in an inappropriate or unwanted sexual manner, with or without penetration.

Generally, sexual abuse is the involvement of children and adolescents in sexual activities they do not truly understand, or that they cannot give informed consent to. Sexual abuse has also been defined as an

adult's use of a child for sexual gratification and may occur on a contact or non-contact basis. For the purpose of this study, child sexual abuse will be defined as occurring to an individual before the age of 18 by a person 5 or more years older than them at the time of the abuse incident. The degree of childhood sexual abuse will be identified by the Childhood Trauma Questionnaire.

Severity of Childhood Sexual Abuse. Substantial research on survivors of child sexual abuse (CSA) has found that sexual abuse is commonly associated with various short-term and long-term consequences which can be detrimental to psychological and physical well-being. Individuals reporting child sexual abuse are at an increased risk of experiencing a myriad of negative outcomes, such as anxiety, depression, post-traumatic stress disorder, revictimization, sexually inappropriate behavior, aggression, low self-esteem, and many others (Browne & Finkelhor, 1986; Himelein, 1995).

However, the presence of negative outcomes may depend on the severity and/or duration of the sexual abuse (Rowan, Foy, Rodriguez, & Ryan, 1994). Individuals with high levels of sexual abuse exposure in which the abuse occurred over long periods of time and in which penetration was involved are more likely to experience

more severe cases of psychological distress and maladjustment (Callahan et al., 2003; Corby, 2001).

In reviewing the research, most investigations on CSA focus on the development of negative outcomes and the maladjustment that can occur as a consequence of the abuse, yet little is known about individuals who experienced sexual abuse and overcame it. It is understood however, that many individuals are resilient and bounce back from various traumatic events, though more research is necessary within the realm of resiliency and CSA survivors. Therefore, in this study it is expected that although women experienced CSA, they will exhibit lower levels of negative outcomes in the presence of high levels of the proposed protective factors.

Outcomes of Abuse

Negative Outcomes. As a consequence of child abuse, survivors may experience negative outcomes in either childhood, adulthood, or both (Browne & Finkelhor, 1986; Lowenthal, 1999). These outcomes impact an individuals' everyday life in their interpersonal relationships and consequently may affect offspring if the issues are not addressed.

A long list of maladaptive behaviors, such as sexually risky behaviors, promiscuity, drug abuse, eating

disorders and alcoholism (e.g. Feinauer & Stuart, 1996); psychiatric disorders, such as anxiety, depression, post-traumatic stress disorder (PTSD), somatic complaints, and dissociation (e.g. Bernet & Stein, 1999; Carlson, Furby, & Armstrong, 1996; Johnson, Pike, & Chard, 2001) have all been correlated with childhood abuse in general. Research on child abuse also determines that children abused by a close relative/adult are at an increased risk of manifesting the above mentioned negative outcomes (Tremblay, Herbert, & Piche, 1999). Also, with certain types of abuse, depending on duration of the abuse, and severity of abuse, the individuals can potentially develop more traumatic outcomes (Browne & Finkelhor, 1986).

Women, in particular are more likely to report certain outcomes of psychological distress, therefore, for the purpose of this study anxiety, depression, and somatic complaints will encompass the psychiatric outcomes factor. The three variables will be measured using the 18-item version of the Brief Symptom Inventory (BSI).

The BSI has been examined across studies with different populations to assess the validity and reliability of the measure. Studies with cancer patients (Novy, Berry, Palmer, Mensing, Wiley, & Bruera, 2004;

Recklitis, Parsons, Shih, Robison, & Zelter, 2006) and one study investigating a low-income population of Latinas found that the short version of the BSI is consistently and validly measuring anxiety, depression, and somatization. Although there are other measures equally reliable, this short version is useful in that it is short and does accurately measure these three psychological distress outcomes common in women who have been abused in childhood and/or adulthood.

Anxiety. One of the strongest risk factors for developing anxiety is a history of severe childhood stress (Asmundson & Carleton, 2005; Floyd, Coulon, Yanez, & Lasota, 2005; Valente, 2005). Neurobiological studies show that high levels of corticotrophin releasing factor (CRF) are released during stress, inducing behaviors reminiscent of fear and anxiety in turn increasing stress responsiveness (Heim & Nemeroff, 2001; Penza, Heim, & Nemeroff, 2003). Most of these studies have been conducted preclinically, however similar findings have been reported in adult patients with mood and anxiety disorders.

Research shows that experiencing childhood abuse is an extremely stressful and traumatic experience. Specifically, studies have found that child physical abuse is strongly correlated with anxiety, while child emotional

abuse is more strongly correlated with depression (Gibb et al., 2003; Heim & Nemeroff, 2001). However, other studies have failed to find associations between a specific type of abuse and specific psychiatric outcomes. For example in Duran et al., investigators sought to determine if there would be a specific relationship between abuse type and outcome. Considering that American Indian populations are at increased risk of experiencing maltreatment, researchers determined that if there were a specific relationship among abuse type and outcome, they would be able to examine it in this population.

However, when examining mental disorders within abuse type, no significant differences were found. Instead investigators substantiated the notion that American Indian women are at high risk, reporting that about 75% of participants experienced at least one type of abuse. Further, within the abused sample, approximately 80% experienced lifetime mental disorders while 60% met major diagnostic criteria for two or more disorders (i.e. 83.3% had a history of anxiety disorders, and 63.0% suffered from PTSD).

In addition, prevalence of mental disorders increased as maltreatment severity increased. Overall, women who were both sexually and physically abused as children, had

the highest rate of reported mental disorders (Duran, Malcoe, Sanders, Waitzkin, Skipper, & Yager, 2004).

It is evident that the experience of childhood abuse can cause severe stress consequently leading to detrimental psychological health and well-being. The trend seems to be that women are at increased risk for developing certain mental disorders in general, however women from disadvantaged populations also seem to be at increased risk for maladjustment in adulthood. This may be due to the lack of outside resources available to them. It is important to conduct more research and apply culturally appropriate interventions for women in minority populations.

Depression. Research has found that depressed individuals typically report histories of child abuse (Bernet & Stein, 1999; Browne & Finkelhor, 1986; Gibb et al., 2003; Johnson, Pike, & Chard, 2001). In these studies, depressive symptoms seem to be prevalent in persons who experienced emotional abuse, physical abuse and/or sexual abuse. Bernet and Stein (1999) examined a Caucasian sample of depressed men and women and their research found statistically significant differences in CTQ scores between depressed patients and the control sample. In particular, depressed patients reported higher

scores on the emotional abuse, emotional neglect, and physical abuse subscales. These findings seem to hold across different ethnic groups, however more severe maladjustment and psychiatric disorders have been reported in minority populations.

Clearly, these studies indicate that a range of problems can arise for both men and women who have been abused during childhood; depressed individuals tend to report histories of abuse, therefore, it is logical to hypothesize that in the proposed study, abuse will directly predict the presence of depression.

Somatic Complaints. Somatization is the presence of physical symptoms with no known physical cause. Like many mental disorders, somatiform disorder is found to be comorbid with depressive symptoms, reports of panic attacks, and alcohol abuse/dependence (Arnd-Caddigan, 2003). Often individuals who have experienced abuse report physical symptoms such as headaches, as well as dizziness, fainting spells and other bodily aches and pains (Emiroglu, Kurul, Akay, & Miral, 2003). Specifically, individuals who report child sexual abuse also report somatic symptoms (Berkowitz, 1998; Emiroglu et al., 2003; Hilker, Murphy, & Kelley, 2005).

A study conducted in France examining gender differences among adolescents who had experienced sexual assault, found that girls were more likely to report somatization whereas boys exhibited more behavior problems. Although this was a French study, similar patterns of abuse were found as in slight older American girls (Darves-Bormoz, Choquet, Ledoux, Gasquet, & Manfredi, 1998).

Another recent study conducted with both boys and girls (ages 9-13) attempted to predict somatic complaints in a primarily African-American sample. In this study researchers found that a higher degree of physical/verbal abuse and higher levels of trauma-related internalizing symptoms (i.e. anxiety, depression, PTSD) significantly predicted somatic symptoms, explaining 62% of the variance (Hilker et al., 2005). The uniqueness in this particular study is methodological in that both child and parent reports were taken. This was one of the first studies to do so.

Research studies have substantiated the notion that somatic symptoms are often present in individuals reporting child abuse experiences however, more research is needed in finding interventions that may ameliorate psychological maladjustment.

Shame. Shame has been identified as a dejection based emotion, which involves feelings of helplessness, incompetence, and a desire to escape or avoid human contact (Fergusson, Stegge, Miller, & Olsen, 1999); the individual is concerned with being rejected and exposing the entire self as defective (Feiring, Taska, & Lewis, 1998). Shame keeps the victim silent, forcing the child to keep the abuse a secret, inhibiting emotional, spiritual and psychological development (Zupancic & Kreidler, 1998).

Moreover, a CSA survivor who experiences shame is more likely to experience the psychiatric outcomes associated with the abuse than persons who experienced CSA but did not experience high levels of shame. For example, a child who received treatment, and was acknowledged by the parents or caretakers when the abuse was disclosed is more likely to lead a functional life than a child who was ignored or blamed for the abuse.

Studies examining shame and self blaming attributions indicate an association between shame and psychological distress (PTSD and depressive symptoms) in children as early as eight weeks following the abuse experience (Feiring et al., 1998). Another study found that shame was a significant predictor of adult anger in men and not women, while shame moderated the relationship

between psychological maltreatment and depressive symptoms for women (Harper & Arias, 2004).

With regard to psychological adjustment, one study found that severity of abuse did not necessarily account for difficulties in adjustment; instead, shame and attributional style accounted for additional variation in adjustment one year following disclosure of abuse (Feiring, Taska, & Lewis, 2002). This finding suggests that if interventions are developed to alleviate the shame experience specific negative outcomes can in turn mitigate. It was hypothesized that shame would mediate the relationship between CSA and negative outcomes. Shame was measured with the Experience of Shame Scale (ESS).

Resiliency Factors. Resilient individuals have the power or ability to return to original form or position after being bent, compressed, or stretched. More appropriately they have the ability to overcome adversity, survive stress and rise above disadvantages (Valentine & Feinauer, 1993). Resiliency research determines that resilient children are able to withstand the negative impact of traumatic experiences and lead functional lives (Wilcox, Richards, O'Keefe, 2001).

As of yet, investigators cannot agree as to what exactly constitutes resiliency. It is only known that

resilient individuals suffer traumatic events but are, in a sense, able to make the best of the situation. A number of different factors have been associated with resilience. Furthermore, it is not only one factor contributing to resiliency but a complex interaction of individual and environmental factors promoting resiliency (Rutter, 1994).

Investigations on resilience have investigated different factors as potentially contributing to resilience, such as social support, family strength, family cohesion, self-esteem, and optimism among others (Carbonell, Reinherz, & Giaconia, 1998; Rak, Patterson, & Lewis, 1996; Wilcox et al., 2004). Studies show that high levels of optimism, social support and self-esteem all lead to positive well-being and healthy functioning (Lowenthal, 1999).

For example, African-American women with low levels of self-efficacy were at an increased risk of attempting suicide because they perceived having low levels of social support from family and friends. Particularly, low levels of self-efficacy were related to low levels of social support (Thompson, Short, Kaslow, & Wycloff, 2002).

Although there is a surplus of research on resiliency and well-being, there is less work within the realm of child abuse. Given that it has been substantiated that

resiliency can buffer the negative impact of different types of stressors and/or traumatic experiences, it can be assumed that factors constituting resiliency can also protect individuals from the negative impact of any type of abuse, including childhood abuse. In this study, level of optimism, self-esteem and degree of social support are considered protective factors that will help individuals withstand the maladaptations caused by childhood abuse and are discussed next.

Optimism. Martin Seligman's research on learned helplessness was a catalyst for the investigations on the constructs behind positive and negative thinking. After his preclinical studies, Seligman (1990) asserted that the phenomenon of pessimism underlined the phenomenon of helplessness. In other words, he felt that helpless individuals believe there is nothing they can do to change any given outcome or course of events in their life, and that pessimists only look at the bad aspects of an event or situation.

Therefore, pessimism or negative thinking can lead to helplessness. On the other hand, when optimists are confronted with a bad or difficult situation they perceive it as a challenge and work harder to attain their goal (Seligman, 1990). In addition, optimists believe that

desired outcomes are attainable, even when they come across roadblocks (Scheier & Carver, 1993). Studies find that positive thinking is beneficial to psychological and physical well-being (Scheier & Carver, 1985; 1992; 1993).

Specifically, a study examining cultural differences between Asian Americans and Caucasian Americans found that Asian Americans were more pessimistic, but not less optimistic than Caucasians. However, Asian Americans did report more depressive and psychological symptoms than Caucasians (Chang, 1996). Based on Scheier and Carver's (1993) research, the term dispositional optimism was developed and operationally defined as "the tendency to believe that one will generally experience good vs. bad outcomes." Furthermore, due to the belief that a positive outlook and believing that good things will happen, can buffer against the negative outcomes associated with traumas, it is presumable that being optimistic can protect survivors of abuse (Scheier & Carver, 1992; 1993). However, to date, there is little research examining the relationship between optimism and child abuse.

In a review of the research, Scheier and Carver (1992) found that positive thinking can lead to better overall health and functioning; however, little research examines the benefits optimism can have on the child abuse

experience. One study, found that good child-parent relationships were associated with increased levels of optimism and that high levels of adversity were associated with decreased levels of optimism. These findings suggest that difficult childhood experiences are more likely to lead to hopelessness and helplessness later in life (Korkeila, Kivela, Suominen, Vahtera, Kivimaki, Sundell, Helenius, & Koskenvuo, 2004).

Another study investigating cancer patients found that optimistic individuals were more likely to continue with their daily life and believed a good outcome was possible, while pessimists tended to give up on life, losing hope, and falling prey to helplessness (Schou, Ekerberg, & Ruland, 2005). With regard to childhood abuse, if individuals have optimistic explanatory styles they can find ways to explain the abuse and place the blame on external factors (i.e. the abuser) leading to healthy outcomes; whereas internalizing the experience (i.e. blaming themselves) will consequently lead to psychological maladjustment. Studies on optimism clearly indicate that positive thinking can be beneficial to psychological and physical well-being.

Social Support. Numerous studies indicate that individuals with a social support system (i.e. spouses,

friends, and family members) are healthier than those with fewer supportive contacts (cited by Cohen & Willis, 1985). Moreover, studies suggest that a social support system can help individuals cope with life stressors (Cassidy, 2005) and can also promote psychological well-being (Cohen & Willis, 1985). Tremblay et al., found that sexually abused children reporting high levels of perceived social support from parents or peers had less adjustment problems, whereas children with a higher degree of severity felt they had less support from friends. It is thought however, that individuals who have developed a support system are more likely to succeed in removing themselves from a violence situation.

For example, CSA survivors who feel supported by their family reported fewer losses than CSA survivors who perceive less support (Murthi & Espelage, 2005). Various studies have found that social support has served as a protective factor and keeps individuals from suffering from psychiatric outcomes that are typically associated with an abusive experience (Day, 2006; Feinauer et al., 2003; Murthi & Espelage, 2005; Thompson et al., 2002).

Murthi and Espelage (2005) discovered that social support served as a mediating factor in women who had experienced child sexual abuse; lesser degrees of

psychological outcomes were reported in these college-age women. Another investigation found that African-American women who had low levels of perceived social support are at increased risk for attempting suicide (Thompson et al., 2002). It was hypothesized that women in this sample who report high levels of social support would report decreased levels of psychological outcomes.

Self-Esteem. Self-esteem is thought to promote psychological well-being (Gray-Little & Hafdahl, 2000; Lieberman, Solomon, & Ginzburg, 2005). Research shows that individuals who have experienced a traumatic event are more likely to have increased levels of psychological suffering and decreased self-esteem (Gray-Little & Hafdahl, 2000; Maxwell, 2003; Quota, Punamaki, & Sarraj, 1995).

Studies on suicidal behavior have found that these individuals tend to have low and/or negative self-esteem. In particular, Lieberman et al., found that suicidal ideation increases with individuals who have low or medium levels of self-esteem, whereas individuals with high self-esteem have lower levels of distress and suicidal behavior. Furthermore, in an investigation conducted with a sample of youth in an emergency shelter it was found that a large percentage of these children had experienced

some type of child abuse. In turn, these children reported significantly low levels of self-esteem and poor overall functioning (Simmons & Weinman, 1991). Another study examining low-income African-American women found that child abuse is a risk factor for increased post-traumatic stress disorder symptoms and decreased self-esteem (Bradley, Schwartz, & Kaslow, 2005).

In general, individuals with low self-esteem are likely to have other psychological maladaptations (Stein, Leslie, & Nyamathi, 2002). Moreover, individuals who have experienced a traumatic event such as child abuse are also likely to have low self-esteem, however there is evidence to support the notion that self-esteem can serve as a buffering factor in the face of traumatizing events, therefore, it was hypothesized that individuals with high self-esteem would report lower levels of psychological distress although they had experienced childhood abuse.

Purpose of the Study. This study sought to determine whether a mediation existed between childhood abuse and negative outcomes among college women. Current research shows that women are negatively impacted by the experience of sexual abuse in childhood, however, little is known regarding the positive impact of resiliency factors within childhood abuse samples.

It is known that resilient individuals can withstand the negative impact of traumatic experiences, therefore the present study assumed that high levels of optimism, social support, and self-esteem would buffer the negative impact of childhood sexual, physical and/or emotional abuse. In other words, it was hypothesized that resiliency (optimism, self-esteem, social support) would moderate the relationship between child abuse and psychiatric outcomes.

CHAPTER TWO

METHODOLOGY

Design

Only female participants who have experienced childhood abuse (sexual, physical and/or emotional) were included in the analysis. Using SPSS Correlations and Multiple Hierarchical Regression, the relationships were examined between Child Abuse, composed of the scores from three variables (child sexual abuse, child physical abuse, and child emotional abuse), Resiliency, composed of three variables (optimism, social support, and self-esteem), and Psychiatric Outcomes, composed of scores from three variables (anxiety symptoms, depressive symptoms, and somatic symptoms). Also included in the analysis was the measured variable shame. The hypothesized model is presented in Figure 1 illustrating the hypothesis that Child Abuse directly affects Psychiatric Outcomes, the mediation effect and the moderation effect.

Participants

The sample of women for this study was taken from archival data which included 704 participants collected from California State University, San Bernardino, California State University, Palm Desert, and various

settings throughout Southern California, from 2004 to 2007. For this study, it was originally proposed to conduct the analysis utilizing Structural Equation Modeling (SEM); however, due to sample size issues, it was not appropriate to conduct SEM, therefore Multiple Regressions was used.

After screening CTQ data, 160 women who reported some degree of child abuse were used for this study. The age of the participants ranged between 18-62. Participants were given the option to participate in the study in exchange for five units of extra credit to use in their psychology courses.

Materials and Scoring

In this study the following materials were used: An informed consent form (see Appendix A), one demographic sheet, (see Appendix B) the Childhood Trauma Questionnaire (CTQ, see Appendix C), the Brief Symptom Inventory (BSI, see Appendix D), the Experience of Shame Scale (ESS, see Appendix E) the Self-Esteem Inventory (SEI, see Appendix F), the Life Orientation Scale (LOT-R, see Appendix G), the Social Support Inventory (SSI, see Appendix H) and a debriefing statement (see Appendix I).

The Informed Consent Form

The informed consent form, included the following information: identification of the researcher(s), explanation of the nature and purpose of the study and the research method, expected duration of research participation, description of how confidentiality and anonymity will be maintained, mention of participants' rights to withdraw their participation and their data from the study at any time without penalty, information about the reasonably foreseeable risks and benefits, the voluntary nature of their participation, and who to contact regarding questions about subjects' rights or injuries.

The Demographic Sheet

The demographic sheet contained the following information: Participants' age, gender, income level, marital status, ethnicity, and education.

The Childhood Trauma Questionnaire

The Childhood Trauma Questionnaire (CTQ; Bernstein et al., 2003) was used to measure the type of abuse: sexual abuse, physical abuse, emotional abuse, emotional neglect, and physical neglect, to identify abuse and extract abuse characteristics. This scale consists of 25 items in total. Five items correspond with and are designed to assess the

severity of each type of abuse. Possible responses to each item range from 1 (Never true) to 5 (Very often true). Eighteen of the 25 items are worded such that "very often true" indicates higher degree of severity. The remaining seven items are worded such that "never true" indicates greater degree of severity. These recoded items will be coded as follows: (with 1 = 5, 2 = 4, 3 = 3, 4 = 2, and 5 = 1). Participants' responses to the 5 items that corresponds to a specific type of abuse (e.g. sexual abuse; after being recoded) will be summed together yielding a total score that could range from 5 (no abuse) to 25 (greater severity of abuse). Cronbach's alpha for participant's responses to the child abuse scale is .84. (Note: Validity data are not available). [See Appendix B for a complete description of the measure].

The Brief Symptoms Inventory

The Brief Symptoms Inventory (BSI; Derogatis, 2001) is a brief inventory of participants' depression, anxiety, and somatization symptoms. This questionnaire is composed of 18 Likert-type items which are rated on the basis of distress over the last 7 days on a 5-point scale from 0 (not at all) to 4 (extremely). Greater scores indicate higher levels of psychiatric symptoms. Cronbach's alpha

coefficient for this measure is .86. [See Appendix D for a complete description of this measure].

The Experience of Shame Scale

The Experience of Shame Scale (ESS; Andrews, Qian, & Valentine, 2002) was used to assess the participants' sense of shame. Higher scores suggest a greater degree of shame. This scale is composed of 25 likert-type items that are rated on a five-point scale from 0 (Never true) to 4 (Almost always). Cronbach's alpha coefficient for this measure is .93. [See Appendix E for a complete description of this measure].

The Self-Esteem Inventory

The Self-Esteem Inventory (SEI; Coopersmith, 1987) consists of 10 Likert-type items, and was designed to assess global self-esteem. The items are rated on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). The scale has adequate internal consistency $\alpha = .77$.

The Life Orientation Test-Revised

The Life Orientation Test-Revised (LOT-R; Scheier, Carver, & Bridges, 1994) was used to assess participants' world view with regard to optimism and pessimism. It is comprised of 10 Likert-type items. Each item is rated on a 5-point scale from 0 (strongly disagree) to 4 (strongly

agree), with a high score indicating greater optimism. The scale has adequate internal consistency $\alpha = .78$.

The Social Support Inventory

The Social Support Inventory (SSI; McCubbin et al., 1988) is a measure of participants' degree of social support. This questionnaire is composed of 18 Likert-type items, which are rated on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). The scale displayed adequate internal consistency $\alpha = .81$.

Debriefing Statement

In the debriefing statement (see Appendix G), participants were informed of the major research questions addressed in the study, they are ensured that their identity will be held anonymous. They will be informed of whom they can contact if they experience major distress due to the study and/or if they want to discuss or obtain the results of the study. Moreover, to ensure the validity of the study, the participants are requested not to discuss the details of the study with potential participants.

Procedure

Volunteers were recruited from California State University of San Bernardino and asked to participate in

the study in exchange for five units of extra credit to be used in their psychology courses. Participants were informed about the general nature of the study (see Appendix A) and were asked to complete a questionnaire package that included a battery of surveys. The surveys used in this study are as follows: a demographic sheet, the Childhood Trauma Questionnaire (CTQ), the Brief Symptoms Inventory (BSI), the Self-Esteem Inventory (SEI), the Revised Life Orientation Test (LOT-R), and the Experience of Shame Scale (ESS).

CHAPTER THREE

RESULTS

Prior to beginning data analysis, the variables in the Sexual Assault Data were examined for out-of-range values, missing data, univariate and multivariate outliers, and skewness, and kurtosis using SPSS DESCRIPTIVES and SPSS REGRESSION. The variables of interest in this prescreening analysis were: subtests of the CTQ (child sexual abuse, child physical abuse, child emotional abuse), shame, subtests of the BSI (anxiety, depression, somatic symptoms), optimism, self-esteem, and social support. Data was collected from 704 female participants. Using Missing Value Analysis (MVA), it was determined that two of the variables had more than 5% missing data: optimism = 169 (27.4%), and self-esteem = 153 (24.8%); child emotional abuse = 4 (.6%), child physical abuse = 5 (.8%), child sexual abuse = 8 (1.3%), social support = 6 (1%), and shame = 3 (.5%). There was complete data for 448 women. Using a criteria of $p < .001$ there were no significant patterns of missing data.

Using a criterion of $z = 3.3$, $p < .001$ five univariate outliers were detected. On the social support

variable, three univariate outliers were recoded to closely fit the distribution of the sample (a score of 9 was recoded to 28; a score of 18 was recoded to 29; and a score of 28 was recoded into 30); one outlier was recoded for self-esteem (a score of 13 = 14 recoded); and one univariate outlier was recoded for optimism (a score of 0 = 1 recoded). Multivariate outliers were examined using Mahalanabois distance with a criterion of $p < .001$. Thirteen multivariate outliers were detected and were deleted from the analysis.

Although all variables were significantly skewed, and five variables were significantly kurtotic, no transformations were made due to the nature of the sample. The variables were severely skewed and transformations would severely impact the ability to interpret the data.

After evaluating assumptions, deleting thirteen multivariate outliers, deleting forty-four cases not collected from a university, and only using participants who reported some type of abuse, 111 cases remained for the moderation analysis, and 160 cases remained for the mediation analysis.

Table 1 displays means, standard deviations and bivariate correlations among study variables.

Using Baron and Kenny (1986) procedures, a series of hierarchical multiple regressions were performed in order to evaluate the relationship between child abuse, shame, and psychiatric outcomes. The predictor variables entered into the equation were child abuse and shame, while psychiatric outcomes was entered as the criterion variable in Step 4. The analysis was conducted in four steps. At step 1, psychiatric outcomes and child abuse were significantly correlated, $r = .296$, $p < .01$, suggesting that there is an effect that can be mediated and Step 2 could be performed. At step 2, shame and child abuse were entered into the equation, with shame as the criterion variable and child abuse as the predictor. Results indicated that the unstandardized coefficient was significantly different from zero, and step 3 and 4 could be performed. At Steps 3 and 4, Child abuse and shame were entered into the equation as predictor variables while psychiatric outcomes was entered as the criterion variable. Results from the final steps indicated a significant difference from zero supplying evidence for the presence of a partial mediation by shame (refer to Table 2).

Unstandardized coefficients and standard errors were entered into a Sobel Test supporting the evidence for

partial mediation by shame, Sobel = 3.48, $p < .01$,
Aroian = 3.46, $p < .01$, Goodman = 3.51, $p < .01$.

A series of hierarchical multiple regressions were conducted in order to determine the relationship between childhood abuse, resiliency, psychiatric outcomes, and the interaction between child abuse and resiliency. The interaction was conducted in order to determine presence of moderation by resiliency (José, 2004). The moderation was tested in three major steps. The centered main effect of child abuse was entered first, the centered main effect of resiliency was entered second, and the centered interaction between the total child abuse score and resiliency was entered third, in predicting psychiatric outcomes. Results indicated that resiliency did not moderate the relationship between child abuse and psychiatric outcomes; therefore a second set of analysis were conducted entering each type of abuse alone.

Child sexual abuse was entered into the equation first, resiliency was entered second, and the centered interaction between child sexual abuse and resiliency was entered third. The moderation was not significant, however at step 2 resiliency explained 37% of the variance in predicting psychiatric outcomes, Multiple $R = .61$
 $F(1, 108) = 31.28$, $p < .01$, $R^2 = .37$, R^2 adjusted = .36

(refer to Table 3). This pattern of analysis was conducted with child physical abuse (Table 4) and child emotional abuse (Table 5), entered at step 1 of the equation, resulting in the same pattern of significance as above. One final series of hierarchical regressions was performed based on theoretical research, testing each type of child abuse and moderation by social support only. At step 1, child emotional abuse was entered into the equation; at step 2 social support was entered into the equation; and at step 3 the centered interaction between child emotional abuse and social support was entered into the equation. The moderation was not significant; however. child emotional abuse entered at step 1 did significantly predict psychiatric outcomes, Multiple $R = .29$ $F(1, 157) = 14.35, p < .01, R^2 = .08, R^2_{\text{adjusted}} = .078$. At step 2, social support explained an additional 15% of the variance, Multiple $R = .49$ $F(1, 156) = 24.18, p < .01, R^2 = .24, R^2_{\text{adjusted}} = .23, R^2_{\text{change}} = .15$ (refer to Table 6).

The steps were followed same as above for child sexual (Table 7) abuse and child physical abuse (Table 8) each at step 1 of the equation to test moderation by social support. The pattern of significance resulted in the same as explained above.

Table 1. Means, Standard Deviations, and Bivariate Correlations of Study Variables

Variable	M	SD	1	2	3	4	5	6
Child Abuse	36.94	12.68	---					
Resiliency	110.77	16.84	-.31**	---				
Psychiatric Outcomes	19.96	14.89	.30**	-.60**	---			
Shame	42.98	20.92	.30**	-.59**	.56**	---		
Child Sexual Abuse	12.40	5.87	.79**	-.13	.20**	.16*	---	
Child Emotional Abuse	13.61	5.19	.84**	-.39**	.28**	.40**	.44**	---
Child Physical Abuse	10.92	4.67	.80**	-.21**	.24**	.17*	.40**	.60**
*p < .05 **p < .01								

Table 2. Regression Results Testing Shame as a Mediator

Independent Variables	B	SE B	β
Step 3			
Child Abuse	.35	.09	.30**
Step 4			
Child Abuse	.17	.08	.14
Shame	.37	.05	.52**

Note: $R^2 = .09$ for Step 3; $\Delta R^2 = .32$ for Step 4.
 n = 160. **p < .01

Table 3. Regression Results Testing Interaction Child Sexual Abuse by Resiliency

Independent Variables	B	SE B	β
Step 1			
Child Sexual Abuse (centered)	-.04	.24	-.02
Step 2			
Child Sexual Abuse (centered)	-.24	.19	-.09
Resiliency (centered)	-.50	.06	-.61**
Step 3			
Child Sexual Abuse (centered)	-.24	.19	-.09
Resiliency (centered)	-.50	.06	-.62**
Child Sexual Abuse x Resiliency (centered interaction)	-.01	.01	-.09

Note: $R^2 = .02$ for Step 1; $\Delta R^2 = .37$ for Step 2; $\Delta R^2 = .01$ for Step 3. $n = 111$. ** $p < .01$

Table 4. Regression Results Testing Interaction Child Physical Abuse by Resiliency

Independent Variables	B	SE B	β
Step 1			
Child Physical Abuse (centered)	.32	.28	.11
Step 2			
Child Physical Abuse (centered)	-.06	.24	-.02
Resiliency (centered)	-.49	.06	-.61**
Step 3			
Child Physical Abuse (centered)	-.05	.25	-.02
Resiliency (centered)	-.49	.06	-.61**
Child Physical Abuse x Resiliency (centered interaction)	.001	.01	.003

Note: $R^2 = .11$ for Step 1; $\Delta R^2 = .35$ for Step 2; $\Delta R^2 = .001$ for Step 3. $n = 111$. ** $p < .01$

Table 5. Regression Results Testing Interaction Child Emotional Abuse by Resiliency

Independent Variables	B	SE B	β
Step 1			
Child Emotional Abuse (centered)	.64	.25	.24
Step 2			
Child Emotional Abuse (centered)	.01	.23	.002
Resiliency (centered)	-.49	.07	-.60**
Step 3			
Child Emotional Abuse (centered)	-.01	.23	-.002
Resiliency (centered)	-.48	.07	-.60**
Child Emotional Abuse x Resiliency (centered interaction)	-.01	.01	-.06

Note: $R^2 = .06$ for Step 1; $\Delta R^2 = .31$ for Step 2; $\Delta R^2 = .004$ for Step 3. $n = 111$. ** $p < .01$

Table 6. Regression Results Testing Interaction Child
Emotional Abuse by Social Support

Independent Variables	B	SE B	β
Step 1			
Child Emotional Abuse (centered)	.83	.22	.29
Step 2			
Child Emotional Abuse (centered)	.58	.21	.20**
Social Support (centered)	-.62	.11	-.40**
Step 3			
Child Emotional Abuse (centered)	.57	.21	.20**
Social Support (centered)	-.60	.11	-.40**
Child Emotional Abuse x Social Support (centered interaction)	-.03	.02	-.09

Note: $R^2 = .08$ for Step 1; $\Delta R^2 = .15$ for Step 2;
 $\Delta R^2 = .01$ for Step 3. $n = 159$. ** $p < .01$

Table 7. Regression Results Testing Interaction Child Sexual Abuse by Social Support

Independent Variables	B	SE B	β
Step 1			
Child Sexual Abuse (centered)	.52	.20	.20**
Step 2			
Child Sexual Abuse (centered)	.40	.18	.16
Social Support (centered)	-.66	.11	-.43**
Step 3			
Child Sexual Abuse (centered)	.41	.18	.16
Social Support (centered)	-.65	.11	-.42--
Child Sexual Abuse x Social Support (centered interaction)	-.02	.02	-.08

Note: $R^2 = .04$ for Step 1; $\Delta R^2 = .18$ for Step 2; $\Delta R^2 = .01$ for Step 3. $n = 159$. ** $p < .01$

Table 8. Regression Results Testing Interaction Child Physical Abuse by Social Support

Independent Variables	B	SE B	β
Step 1			
Child Physical Abuse (centered)	.76	.25	.24**
Step 2			
Child Physical Abuse (centered)	.49	.23	.15*
Social Support (centered)	-.63	.11	-.41**
Step 3			
Child Physical Abuse (centered)	.47	.24	.15*
Social Support (centered)	-.63	.11	-.41**
Child Physical Abuse x Social Support (centered interaction)	-.01	.03	-.02

Note: $R^2 = .06$ for Step 1; $\Delta R^2 = .16$ for Step 2; $\Delta R^2 = .01$ for Step 3. $n = 159$. ** $p < .01$

CHAPTER FOUR

DISCUSSION

It was hypothesized that shame would mediate the relationship between child abuse and psychiatric outcomes. Results indicated significant findings among these three variables, suggesting shame partially mediated the relationship between child abuse and psychiatric outcomes. Specifically, women who reported experiencing child abuse (i.e., sexual, physical and emotional) reported higher levels of psychiatric outcomes (i.e., depression, somatic, and anxiety symptoms). In addition, experience of child abuse was associated to feelings of shame, and subsequently, the experience of shame led women to report higher levels of psychiatric symptoms.

Secondly, it was hypothesized that resiliency would moderate the relationship between child abuse and psychiatric outcomes. Results indicated that resiliency did not moderate the relationship between the variables of interest. It was thought that possibly, a moderation effect could not be detected with the combined scores for resiliency (i.e. social support, optimism, and self-esteem). Therefore, a second set of analysis was performed, in which only social support was tested as a

moderator between each type of child abuse and psychiatric outcomes. Again, results indicated that social support as an indicator of resiliency did not moderate the relationship between the types of child abuse and psychiatric outcomes.

Discussion of the Findings

Mediation

Previous research has repeatedly shown that child abuse leads to severe difficulties in childhood and adulthood (Browne & Finkelhor, 1986). The current study supports previous findings in that, women who reported experiencing some type of child abuse, leading to shame, reported higher levels of psychiatric outcomes (Feiring et al., 1998; 2002; Harper, & Arias, 2004).

According to the stigmatization dynamic, (Finkelhor & Browne, 1985) a stigma is associated with the experience of child sexual abuse, leading the child to experience feelings of guilt and shame, incorporating negative connotations of the self into their self-image. This shame can be the result of the child sexual abuse, or from adverse reactions from parents, caretakers, or peers following disclosure of the abuse. Consistent with the Traumagenics Model (Finkelhor & Browne, 1985), these

feelings of shame do not seem to easily disappear but rather continue on into adulthood, especially when the effects are not treated through clinical therapy. In this particular study, shame symptoms were assessed within the last year as opposed to during childhood, therefore, the fact that shame still predicted high levels of psychiatric outcomes suggests that shame is long-lasting, providing support for the stigmatization dynamic.

Previous findings and results from the current study suggest that although child abuse alone is problematic for women in adulthood, the experience of child abuse also leads to shame, increasing the levels of anxiety, depression, and somatic symptoms. Therefore, it is imperative to treat the shame feelings occurring consequent to the abuse experience.

Clinical Implications

Moreover, given the results of this study, it may be assumed that diminishing these specific feelings of shame can alleviate these psychiatric outcomes. In accordance with the stigmatization dynamic, during clinical therapy, a child can be provided with appropriate treatment to mitigate feelings of stigma, self-blame, and negative schemas that have been developed as a consequence of the child abuse experience (Finkelhor & Browne, 1985).

It is interesting however, that in spite of their child abuse experience, shame feelings, and psychiatric symptoms, these women were still able to endure and enter into a 4-year university. It is still unclear as to what makes these women different. This continues to be a quandary among child abuse research because it is known that many women experience child abuse, yet many are seen as resilient.

Cognitive-behavior therapy has been useful in treating women who suffer from post-traumatic stress disorder after experiencing rape (Jaycox, Zoellner, & Foa, 2002); therefore, a form of cognitive therapy can be utilized in adults who have experienced child abuse and are still suffering the negative consequences of the trauma with emphasis placed on alleviating feelings of shame and guilt (Finkelhor & Browne, 1985).

Interestingly, clinical research shows that both men and women do not disclose their symptoms of depression or distress in therapy due to shame feelings (Hook & Andrews, 2005). However, another study found no relationship between shame feelings and disclosure instead disclosure was related to the strength of the therapeutic relationship (Farber & Hall, 2002). A review of effective interventions found that didactic forms of treatment are

useful in treating child maltreatment; however, it was not determined that one form of treatment was not found superior to another albeit when group treatment was combined with in-home visits, families were more likely to stay in treatment longer (Howing, Wodarski, Gaudin, & Kurtz, 1989; Martsolf, & Draucker, 2005).

Moderation

Resiliency was hypothesized to moderate the relationship between child abuse and psychiatric outcomes. Findings indicated that a moderation did not exist in this sample of college women; however results suggested that a high degree of resiliency predicted lower levels of psychiatric outcomes. After this first analysis, a second set of analyses was performed to test if possibly social support alone would moderate the relationship between each type of child abuse and psychiatric outcomes. Again, a moderation was not detected, and the pattern of results were similar as above in which a strong social support system predicted decreased levels of psychiatric outcomes.

These findings, although not expected, are still important. The fact that reporting a high degree of resiliency, particularly, a strong social support system, decreased the degree of anxiety, depression, and somatic symptom scores, shows that some form of resiliency is

important for women who have experienced child emotional abuse, child sexual abuse, and child physical abuse.

Previous studies have found that a social support system can be beneficial in many different situations, (Cassidy, 2005; Day, 2006; Karademas, 2006) particularly in times of stress (Thompson et al., 2002) and for individuals in abusive relationships (Holt & Espelage, 2005). Women who felt they had someone they could count on, and felt they were part of a community have been better able to deal with difficult situations.

Clinical Implications

Because the presence of social support did explain some variance in predicting the reduction of psychiatric outcomes in women who had experienced each type of abuse, it may be helpful to develop therapy groups in which women can discuss their abuse experiences and consequent psychological difficulties with each other (Martsolf & Draucker, 2005), in turn, alleviating some of their psychological distress. If a therapy session could replicate the concept of social support in a group, this may be beneficial to survivors of abuse.

Limitations and Future Research

With regard to the mediation, it is critical to note that it is not known how much each type of child abuse contributed to the total child abuse score. In other words, because a total child abuse score was entered into the regression equation, it cannot be determined if one type of child abuse had more influence than another. A plausible follow up study would be to determine the variance explained by each type of abuse. Finkelhor and Browne (1985) suggest that it is primarily child sexual abuse which leads to feelings of shame, therefore, teasing these variables out would be beneficial in developing therapy sessions.

In addition, a larger sample size would allow examination of this path analysis through Structural Equation Modeling in which these relationships could be examined more deeply.

With regard to the moderation by resiliency, sample size was relatively small and it is possible that if a moderation did exist, it could not be detected due to a lack of power (Jaccard, Wan, & Turris, 1990; Jaccard & Wan, 1995). Furthermore, it would be interesting to test whether optimism, social support and self-esteem do in fact make up the resiliency construct which again, could

be tested through the use of SEM; however, a larger sample size would be necessary in order to employ the analyses.

External Validity

The sample used for this study was a college sample of women from Southern California, therefore it may be difficult to generalize findings to the general population. Nonetheless, these findings although perhaps somewhat limited in generalizability, still can help shed light on the impact of child abuse and methods for mitigation of this issue.

Conclusions

From this study, it is evident that there continues to be a serious problem among women who have experienced child abuse. Not only must these individuals endure the traumatic childhood experience, but experiencing child abuse leads to shame, in turn, leading to increased levels of somatic symptoms, anxiety, and depressive symptoms. It would be useful for these women to seek therapy as adults; however, if they have experienced shame it may be difficult for them to do so, as the shame feelings may not allow them to disclose their experience to an unknown therapist (Farber & Hall, 2002).

The current study was unable to show that resiliency buffers the negative impact of child abuse; however, it

was shown that women who reported a strong social support system reported less psychiatric symptoms. It is possible that women at a university are able to establish strong relationships with other students or may have already had strong relationships with people prior to entering college. However, these results are inconclusive and another study should be conducted in which these relationships can be examined more closely.

To conclude, it is pivotal to continue research on child abuse; however, it is just as essential to apply interventions for women who have experienced these traumas. If these women entered a therapy group in which they addressed their feelings of shame, this alone could be beneficial in alleviating anxiety, depressive, and somatic symptoms (Howing, Wodarski, Gaudin, & Kurtz, 1989; Martsolf, & Draucker, 2005). Furthermore, as the ecological system model suggests, it is important to have treatment for both the parents who have experienced abuse and/or are presently in abusive relationships, as well as therapy sessions for the children of these families (Osofsky, 2003).

APPENDIX A
INFORMED CONSENT FORM

Informed Consent Form

The following study is designed to measure potentially traumatic experiences in childhood and adulthood as well as factors that may facilitate resiliency in women. This study is being conducted by Laura Luna under the supervision of Dr. David Chavez, Associate Professor of Psychology at the California State University, San Bernardino (CSUSB). This study has been reviewed and approved by the Institutional Review Board of CSUSB. The University requires that you give your consent before participating in this study. In this study you will be asked to complete a packet of questionnaires designed to measure traumatic experiences, resiliency, and mental health. The packet should take approximately 45 min. to 1 hour to complete. All of your responses will be anonymous. At no time will your name be requested or recorded during your participation. Presentation of the results will be reported in group format only. Upon completion of this study (June, 2007), you may receive a report of the group results. Your participation in the study is entirely voluntary. You are free to withdraw your participation at any time during the study without penalty or remove any data at any time. No services currently being provided to you will be affected if you choose not to participate. When you complete the packet of questionnaires, you will receive a debriefing statement describing the study in more detail and, if you are a CSUSB student, at your instructor's discretion, you may receive a slip for five units of extra credit. If you have any questions concerning this study or your participation in this research, please feel free to contact Dr. David Chavez at (909) 880-5572. I acknowledge that I have been informed of, and understand the nature and purpose of the study, and I freely consent to participate. I acknowledge that I am at least 18 years of age.

APPENDIX B
DEMOGRAPHICS

Demographics

Instructions: Please fill in each item below.

Your age: _____

Your gender (circle one): Male Female

Marital Status (circle one): Single Married
 Divorced/Separated Other _____

Ethnicity

Check the statement that best describes your ethnic background

<input type="checkbox"/> Asian-American	<input type="checkbox"/> Mexican-American/Chicano
<input type="checkbox"/> American Indian	<input type="checkbox"/> Hispanic/Latino (non Mexican-American)
<input type="checkbox"/> Black (non-Hispanic, including African American)	<input type="checkbox"/> Pacific Islander
<input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> White (non Hispanic/Latino)

Education

Your highest level of education completed

☐ Grade School/Middle School
☐ Some High School
☐ High School Diploma/GED
☐ Some College
☐ Associates Degree
☐ Bachelors Degree
☐ Post Graduate Degree

Yearly Gross Income

Check the statement that most nearly reflects your family's annual gross income

<input type="checkbox"/> Less than \$4,999	<input type="checkbox"/> 55,000 to 64,999
<input type="checkbox"/> 5,000 to 14,999	<input type="checkbox"/> 65,000 to 74,999
<input type="checkbox"/> 15,000 to 24,999	<input type="checkbox"/> 75,000 or more
<input type="checkbox"/> 25,000 to 34,999	
<input type="checkbox"/> 35,000 to 44,999	
<input type="checkbox"/> 45,000 to 54,999	

APPENDIX C
CHILDHOOD TRAUMA QUESTIONNAIRE

Childhood Trauma Questionnaire (CTQ)

Instructions: These questions ask about some of your experiences growing up as a child and a teenager. Although these questions are of a personal nature, please try to answer as honestly as you can.

1 = Never True

3 = Sometimes True

2 = Rarely True

4 = Often True

5 = Very Often True

When I was growing up...

1 I didn't have enough to eat. 1 2 3 4 5

2 I knew that there was someone to take care of me and protect me. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Parent's Boyfriend or Girlfriend |
| <input type="checkbox"/> Father | <input type="checkbox"/> Ones Own Relationship Partner |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Foster Parent/Someone in the Home |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Cousin |
| <input type="checkbox"/> Both Parents | <input type="checkbox"/> Sibling(s) |
| <input type="checkbox"/> Stepparent | <input type="checkbox"/> Babysitter |
| <input type="checkbox"/> School Personnel | <input type="checkbox"/> Stranger |
| <input type="checkbox"/> Other: _____ | |

3 People in your family called you things like, stupid, lazy or ugly. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Parent's Boyfriend or Girlfriend |
| <input type="checkbox"/> Father | <input type="checkbox"/> Ones Own Relationship Partner |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Foster Parent/Someone in the Home |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Cousin |
| <input type="checkbox"/> Both Parents | <input type="checkbox"/> Sibling(s) |
| <input type="checkbox"/> Stepparent | <input type="checkbox"/> Babysitter |
| <input type="checkbox"/> School Personnel | <input type="checkbox"/> Stranger |
| <input type="checkbox"/> Other: _____ | |

4 My parents were too drunk or too high to take care of the family. 1 2 3 4 5

5	There was someone in my life that helped me feel that I was important or special.	1	2	3	4	5
If you answered 2 - 5, please specify who (check all that apply):						
<input type="checkbox"/> Mother		<input type="checkbox"/> Parent's Boyfriend or Girlfriend				
<input type="checkbox"/> Father		<input type="checkbox"/> Ones Own Relationship Partner				
<input type="checkbox"/> Family member		<input type="checkbox"/> Foster Parent/Someone in the Home				
<input type="checkbox"/> Friend		<input type="checkbox"/> Cousin				
<input type="checkbox"/> Both Parents		<input type="checkbox"/> Sibling(s)				
<input type="checkbox"/> Stepparent		<input type="checkbox"/> Babysitter				
<input type="checkbox"/> School Personnel		<input type="checkbox"/> Stranger				
Other: _____						
6	I had to wear dirty clothes.	1	2	3	4	5
7	I felt loved.	1	2	3	4	5
8	I thought that my parents wished I had never been born.	1	2	3	4	5
9	I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.	1	2	3	4	5
If you answered 2 - 5, please specify who (check all that apply):						
<input type="checkbox"/> Mother		<input type="checkbox"/> Parent's Boyfriend or Girlfriend				
<input type="checkbox"/> Father		<input type="checkbox"/> Ones Own Relationship Partner				
<input type="checkbox"/> Family member		<input type="checkbox"/> Foster Parent/Someone in the Home				
<input type="checkbox"/> Friend		<input type="checkbox"/> Cousin				
<input type="checkbox"/> Both Parents		<input type="checkbox"/> Sibling(s)				
<input type="checkbox"/> Stepparent		<input type="checkbox"/> Babysitter				
<input type="checkbox"/> School Personnel		<input type="checkbox"/> Stranger				
Other: _____						
10	There was nothing I wanted to change about my family.	1	2	3	4	5
11	People in my family hit me so hard that it left me with bruises or marks.	1	2	3	4	5
If you answered 2 - 5, please specify who (check all that apply):						
<input type="checkbox"/> Mother		<input type="checkbox"/> Parent's Boyfriend or Girlfriend				
<input type="checkbox"/> Father		<input type="checkbox"/> Ones Own Relationship Partner				
<input type="checkbox"/> Family member		<input type="checkbox"/> Foster Parent/Someone in the Home				
<input type="checkbox"/> Friend		<input type="checkbox"/> Cousin				
<input type="checkbox"/> Both Parents		<input type="checkbox"/> Sibling(s)				
<input type="checkbox"/> Stepparent		<input type="checkbox"/> Babysitter				
<input type="checkbox"/> School Personnel		<input type="checkbox"/> Stranger				
Other: _____						

12 I was punished with a belt, a board, a cord, or some other hard object. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

<input type="checkbox"/> Mother	<input type="checkbox"/> Parent's Boyfriend or Girlfriend
<input type="checkbox"/> Father	<input type="checkbox"/> Ones Own Relationship Partner
<input type="checkbox"/> Family member	<input type="checkbox"/> Foster Parent/Someone in the Home
<input type="checkbox"/> Friend	<input type="checkbox"/> Cousin
<input type="checkbox"/> Both Parents	<input type="checkbox"/> Sibling(s)
<input type="checkbox"/> Stepparent	<input type="checkbox"/> Babysitter
<input type="checkbox"/> School Personnel	<input type="checkbox"/> Stranger
<input type="checkbox"/> Other: _____	

13 People in my family looked out for each other. 1 2 3 4 5

14 People in my family said hurtful or insulting things to me. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

<input type="checkbox"/> Mother	<input type="checkbox"/> Parent's Boyfriend or Girlfriend
<input type="checkbox"/> Father	<input type="checkbox"/> Ones Own Relationship Partner
<input type="checkbox"/> Family member	<input type="checkbox"/> Foster Parent/Someone in the Home
<input type="checkbox"/> Friend	<input type="checkbox"/> Cousin
<input type="checkbox"/> Both Parents	<input type="checkbox"/> Sibling(s)
<input type="checkbox"/> Stepparent	<input type="checkbox"/> Babysitter
<input type="checkbox"/> School Personnel	<input type="checkbox"/> Stranger
<input type="checkbox"/> Other: _____	

15 I believe I was physically abused. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

<input type="checkbox"/> Mother	<input type="checkbox"/> Parent's Boyfriend or Girlfriend
<input type="checkbox"/> Father	<input type="checkbox"/> Ones Own Relationship Partner
<input type="checkbox"/> Family member	<input type="checkbox"/> Foster Parent/Someone in the Home
<input type="checkbox"/> Friend	<input type="checkbox"/> Cousin
<input type="checkbox"/> Both Parents	<input type="checkbox"/> Sibling(s)
<input type="checkbox"/> Stepparent	<input type="checkbox"/> Babysitter
<input type="checkbox"/> School Personnel	<input type="checkbox"/> Stranger
<input type="checkbox"/> Other: _____	

16 I had the perfect childhood. 1 2 3 4 5

17 I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor, or doctor. 1 2 3 4 5

If you answered 2 - 5, please specify who hit you (check all that apply):

<input type="checkbox"/> Mother	<input type="checkbox"/> Parent's Boyfriend or Girlfriend
<input type="checkbox"/> Father	<input type="checkbox"/> Ones Own Relationship Partner
<input type="checkbox"/> Family member	<input type="checkbox"/> Foster Parent/Someone in the Home
<input type="checkbox"/> Friend	<input type="checkbox"/> Cousin
<input type="checkbox"/> Both Parents	<input type="checkbox"/> Sibling(s)
<input type="checkbox"/> Stepparent	<input type="checkbox"/> Babysitter
<input type="checkbox"/> School Personnel	<input type="checkbox"/> Stranger
<input type="checkbox"/> Other: _____	

18 I felt that someone in my family hated me. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Parent's Boyfriend or Girlfriend |
| <input type="checkbox"/> Father | <input type="checkbox"/> Ones Own Relationship Partner |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Foster Parent/Someone in the Home |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Cousin |
| <input type="checkbox"/> Both Parents | <input type="checkbox"/> Sibling(s) |
| <input type="checkbox"/> Stepparent | <input type="checkbox"/> Babysitter |
| <input type="checkbox"/> School Personnel | <input type="checkbox"/> Stranger |
| <input type="checkbox"/> Other: _____ | |

19 People in my family felt close to each other. 1 2 3 4 5

20 Someone tried to touch me in a sexual way, or tried to make me touch them. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Parent's Boyfriend or Girlfriend |
| <input type="checkbox"/> Father | <input type="checkbox"/> Ones Own Relationship Partner |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Foster Parent/Someone in the Home |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Cousin |
| <input type="checkbox"/> Both Parents | <input type="checkbox"/> Sibling(s) |
| <input type="checkbox"/> Stepparent | <input type="checkbox"/> Babysitter |
| <input type="checkbox"/> School Personnel | <input type="checkbox"/> Stranger |
| <input type="checkbox"/> Other: _____ | |

21 Someone threatened to hurt me or tell lies about me unless I did something sexual with them. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Parent's Boyfriend or Girlfriend |
| <input type="checkbox"/> Father | <input type="checkbox"/> Ones Own Relationship Partner |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Foster Parent/Someone in the Home |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Cousin |
| <input type="checkbox"/> Both Parents | <input type="checkbox"/> Sibling(s) |
| <input type="checkbox"/> Stepparent | <input type="checkbox"/> Babysitter |
| <input type="checkbox"/> School Personnel | <input type="checkbox"/> Stranger |
| <input type="checkbox"/> Other: _____ | |

22 I had the best family in the world. 1 2 3 4 5

23 Someone tried to make me do sexual things or watch sexual things. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Parent's Boyfriend or Girlfriend |
| <input type="checkbox"/> Father | <input type="checkbox"/> Ones Own Relationship Partner |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Foster Parent/Someone in the Home |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Cousin |
| <input type="checkbox"/> Both Parents | <input type="checkbox"/> Sibling(s) |
| <input type="checkbox"/> Stepparent | <input type="checkbox"/> Babysitter |
| <input type="checkbox"/> School Personnel | <input type="checkbox"/> Stranger |
| <input type="checkbox"/> Other: _____ | |

24 Someone molested me. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Parent's Boyfriend or Girlfriend |
| <input type="checkbox"/> Father | <input type="checkbox"/> Ones Own Relationship Partner |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Foster Parent/Someone in the Home |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Cousin |
| <input type="checkbox"/> Both Parents | <input type="checkbox"/> Sibling(s) |
| <input type="checkbox"/> Stepparent | <input type="checkbox"/> Babysitter |
| <input type="checkbox"/> School Personnel | <input type="checkbox"/> Stranger |
| <input type="checkbox"/> Other: _____ | |

25 I believed that I was emotionally abused. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Parent's Boyfriend or Girlfriend |
| <input type="checkbox"/> Father | <input type="checkbox"/> Ones Own Relationship Partner |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Foster Parent/Someone in the Home |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Cousin |
| <input type="checkbox"/> Both Parents | <input type="checkbox"/> Sibling(s) |
| <input type="checkbox"/> Stepparent | <input type="checkbox"/> Babysitter |
| <input type="checkbox"/> School Personnel | <input type="checkbox"/> Stranger |
| <input type="checkbox"/> Other: _____ | |

26 There was someone to take me to the doctor if I needed it. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Parent's Boyfriend or Girlfriend |
| <input type="checkbox"/> Father | <input type="checkbox"/> Ones Own Relationship Partner |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Foster Parent/Someone in the Home |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Cousin |
| <input type="checkbox"/> Both Parents | <input type="checkbox"/> Sibling(s) |
| <input type="checkbox"/> Stepparent | <input type="checkbox"/> Babysitter |
| <input type="checkbox"/> School Personnel | <input type="checkbox"/> Stranger |
| <input type="checkbox"/> Other: _____ | |

27 I believed that I was sexually abused. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Parent's Boyfriend or Girlfriend |
| <input type="checkbox"/> Father | <input type="checkbox"/> Ones Own Relationship Partner |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Foster Parent/Someone in the Home |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Cousin |
| <input type="checkbox"/> Both Parents | <input type="checkbox"/> Sibling(s) |
| <input type="checkbox"/> Stepparent | <input type="checkbox"/> Babysitter |
| <input type="checkbox"/> School Personnel | <input type="checkbox"/> Stranger |
| <input type="checkbox"/> Other: _____ | |

28 My family was a source of strength and support. 1 2 3 4 5

APPENDIX D
BRIEF SYMPTOMS INVENTORY

Brief Symptoms Inventory (BSI)

Instructions: Below is a list of problems people sometimes have. Read each one carefully and circle the number that best describes your answer. HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Do not skip any items. If you have any questions, please ask them now.

0 = NOT AT ALL

2 = MODERATELY

4 = EXTREMELY

1 = A LITTLE BIT

3 = QUITE A BIT

How much were you distressed by:

1.	0	1	2	3	4	Faintness or dizziness
2.	0	1	2	3	4	Feeling no interest in things
3.	0	1	2	3	4	Nervousness or shakiness inside
4.	0	1	2	3	4	Pains in heart or chest
5.	0	1	2	3	4	Feeling lonely
6.	0	1	2	3	4	Feeling tense or keyed up
7.	0	1	2	3	4	Nausea or upset stomach
8.	0	1	2	3	4	Feeling blue
9.	0	1	2	3	4	Suddenly scared for no reason
10.	0	1	2	3	4	Trouble getting your breath
11.	0	1	2	3	4	Feelings of worthlessness
12.	0	1	2	3	4	Spells of terror or panic
13.	0	1	2	3	4	Numbness or tingling in parts of your body
14.	0	1	2	3	4	Feeling hopeless about the future
15.	0	1	2	3	4	Feeling so restless you couldn't sit still
16.	0	1	2	3	4	Feeling weak in parts of your body
17.	0	1	2	3	4	Thoughts of ending your life
18.	0	1	2	3	4	Feeling Fearful

APPENDIX E
EXPERIENCE OF SHAME SCALE

Experience of Shame Scale (ESS)

Instructions: Everybody can feel embarrassed, self-conscious or ashamed at times. Below are a series of questions about such feelings. Please indicate if this feeling has occurred *at any time in the past year*. Be as honest as possible. Remember that there are no right or wrong answers. Read each item carefully and decide how you feel about it; then circle the number of the item that best describes your feelings in the past year. Put down your first impressions. Please answer every item.

0 = Never

1 = Rarely

2 = Sometimes

3 = Often

4 = Almost Always

1	Have you felt ashamed of any of your personal habits?	0	1	2	3	4
2	Have you worried about what other people think of any of your personal habits?	0	1	2	3	4
3	Have you tried to cover up or conceal any of your personal habits?	0	1	2	3	4
4	Have you felt ashamed of your manner with others	0	1	2	3	4
5	Have you avoided people because of your manner?	0	1	2	3	4
6	Have you felt ashamed of the sort of person you are?	0	1	2	3	4
7	Have you worried about what other people think of you?	0	1	2	3	4
8	Have you tried to conceal the sort of person that you are from others?	0	1	2	3	4
9	Have you felt ashamed of your ability to do things?	0	1	2	3	4
10	Have you worried about what other people think of your ability to do things?	0	1	2	3	4
11	Have you avoided people because of your inability to do things?	0	1	2	3	4
12	Do you feel ashamed when you do something wrong?	0	1	2	3	4
13	Have you worried about what other people think of you when you do something wrong?	0	1	2	3	4
14	Have you tried to cover up or conceal things you felt ashamed of having done?	0	1	2	3	4
15	Have you felt ashamed when you said something you felt was stupid?	0	1	2	3	4

16	Have you worried about what others people think of you when you say something stupid?	0	1	2	3	4
17	Have you avoided contact with anyone who knew you had said something stupid?	0	1	2	3	4
18	Have you felt ashamed when you failed at something that was important to you?	0	1	2	3	4
19	Have you worried about what other people think of you when you fail?	0	1	2	3	4
20	Have you avoided people who have seen you fail?	0	1	2	3	4
21	Have you felt ashamed of your body or any part of it?	0	1	2	3	4
22	Have you worried about what other people think of your appearance?	0	1	2	3	4
23	Have you avoided looking at yourself in the mirror?	0	1	2	3	4
24	Have you wanted to hide or conceal your body or any part of it?	0	1	2	3	4

APPENDIX F
SELF-ESTEEM INVENTORY

Self-Esteem Inventory (SEI)

Instructions: The following statements refer to feelings about you. Please indicate how much you agree with each of the following statements. Be as honest as possible. Remember that there are no right or wrong answers to the questions. Please answer every item.

1 = Strongly Disagree

4 = Agree

2 = Disagree

5 = Strongly Agree

3 = Neither Agree nor Disagree

1	On the whole, I am satisfied with myself	1	2	3	4	5
2	At times I think that I am no good at all	1	2	3	4	5
3	I feel that I have a number of good qualities	1	2	3	4	5
4	I am able to do things as well as most other people	1	2	3	4	5
5	I feel I do not have much to be proud of	1	2	3	4	5
6	I certainly feel useless at times	1	2	3	4	5
7	I feel that I am a person of worth, at least on an equal plane with others	1	2	3	4	5
8	I wish I could have more respect for myself	1	2	3	4	5
9	All in all, I am inclined to think that I am a failure	1	2	3	4	5
10	I take a positive attitude toward myself	1	2	3	4	5

APPENDIX G
LIFE ORIENTATION TEST-REVISED

Life Orientation Test-Revised (LOT-R)

Instructions: Below are a series of statements that describes attitudes and behaviors. Please indicate how much you agree with each of the following statements in general. Try not to let one answer influence another. Remember that there are no right or wrong answers; just give your own honest opinions. Please answer every item.

0 = Strongly Disagree

1 = Disagree

2 = Neither Agree nor Disagree

3 = Agree

4 = Strongly Agree

1	In uncertain times, I usually expect the best.	0	1	2	3	4
2	Its easy for me to relax.	0	1	2	3	4
3	If something can go wrong for me, it will.	0	1	2	3	4
4	I'm always optimistic about my future.	0	1	2	3	4
5	I enjoy my friends a lot.	0	1	2	3	4
6	Its important for me to keep busy	0	1	2	3	4
7	I hardly ever expect things to go my way	0	1	2	3	4
8	I don't get upset too easily	0	1	2	3	4
9	I rarely count on good things happening to me.	0	1	2	3	4
10	Overall, I expect more good things to happen to me than bad.	0	1	2	3	4

APPENDIX H
SOCIAL SUPPORT INVENTORY

Social Support Inventory (SSI)

Instructions: The following statements refer to feelings and experiences that may or may not be characteristic of your relationships with family, friends, and your community. Please indicate how much you agree with each of the following statements. Be as honest as possible. Remember that there are no right or wrong answers to the questions. Read each item and decide how you feel about it; then circle the number of the item that best describes that situation. Put down your first impressions. Please answer every item.

1 = Strongly Disagree

4 = Agree

2 = Disagree

5 = Strongly Agree

3 = Neither Agree nor Disagree

1	If I had an emergency, even people I do not know in my community would be willing to help	1	2	3	4	5
2	I feel good about myself when I sacrifice and give time and energy to members of my family	1	2	3	4	5
3	The things I do for members of my family, and they do for me, make me feel part of this important group	1	2	3	4	5
4	People in my community know that they can get help from the community if they are in trouble	1	2	3	4	5
5	I have friends who let me know they value who I am and what I can do	1	2	3	4	5
6	People can depend on each other in my community	1	2	3	4	5
7	Members of my family seldom listen to my problems or concerns	1	2	3	4	5
8	My friends in my community are a part of my everyday activities	1	2	3	4	5
9	There are times when family members do things that make other members unhappy	1	2	3	4	5
10	I need to be very careful how much I do for my friend because they take advantage of me	1	2	3	4	5
11	Living in my community gives me a secure feeling	1	2	3	4	5
12	The members of my family make an effort to show their love and affection for me	1	2	3	4	5
13	There is a feeling in my community that people should not get too friendly with each other	1	2	3	4	5
14	My community is not a very good community to bring children up in	1	2	3	4	5
15	I feel secure that I am as important to my friends as they are to me	1	2	3	4	5
16	I have some very close friends outside the family who I know really care and love me	1	2	3	4	5
17	Member(s) of my family do not seem to understand me	1	2	3	4	5

APPENDIX I
DEBRIEFING STATEMENT

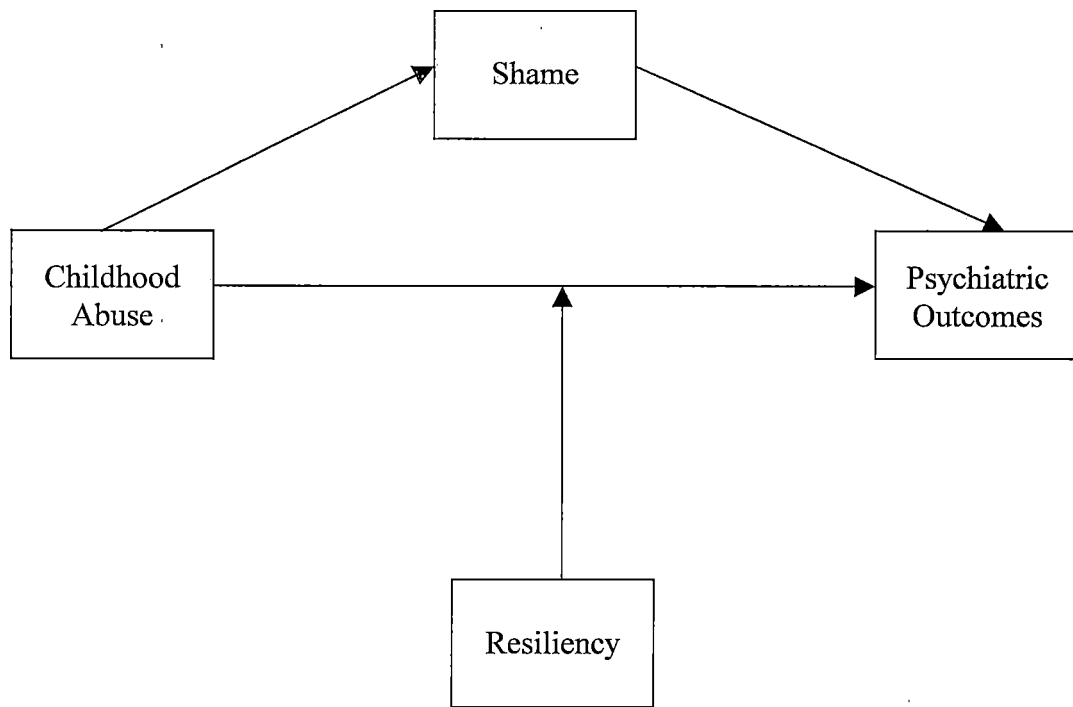
Debriefing Statement

The study you have just completed was designed to investigate the relationship of ethnic identity, stress, social support, self-efficacy and methods of coping in women that have potentially experienced sexual assault in childhood and/or adulthood. Specifically, we are interested in examining the role each factor plays in resiliency and mental health among women. Most research concerning sexual assault has focused on the negative impact of those experiences. The purpose of the present study is to also investigate factors that help women cope with these experiences. It is hoped that this information may be useful in the development of optimal intervention programs for women who have experienced sexual assault.

The anonymity of your identity and data results are guaranteed in accordance with professional and ethical guidelines set by the CSUSB Department of Psychology Institutional Review Board and the American Psychological Association. The focus of this research is at a group level and not on an individual level. If you are interested in the results of this study (after July 2005) or if you have any questions concerning your participation in this study, please contact Dr. David Chavez at (909) 880-5572. Additionally, you are being provided with pamphlets that give you information about services in the area that you are women you know may benefit from.

APPENDIX J

FIGURE 1



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